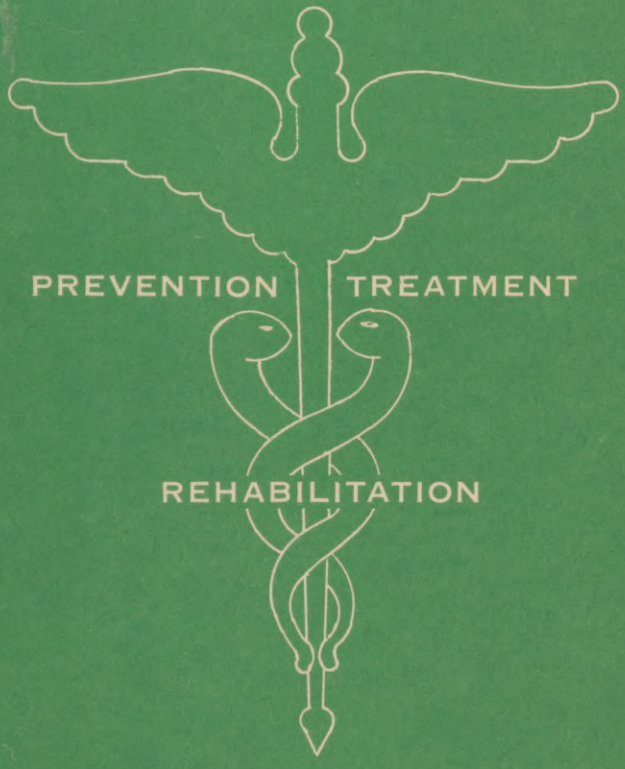
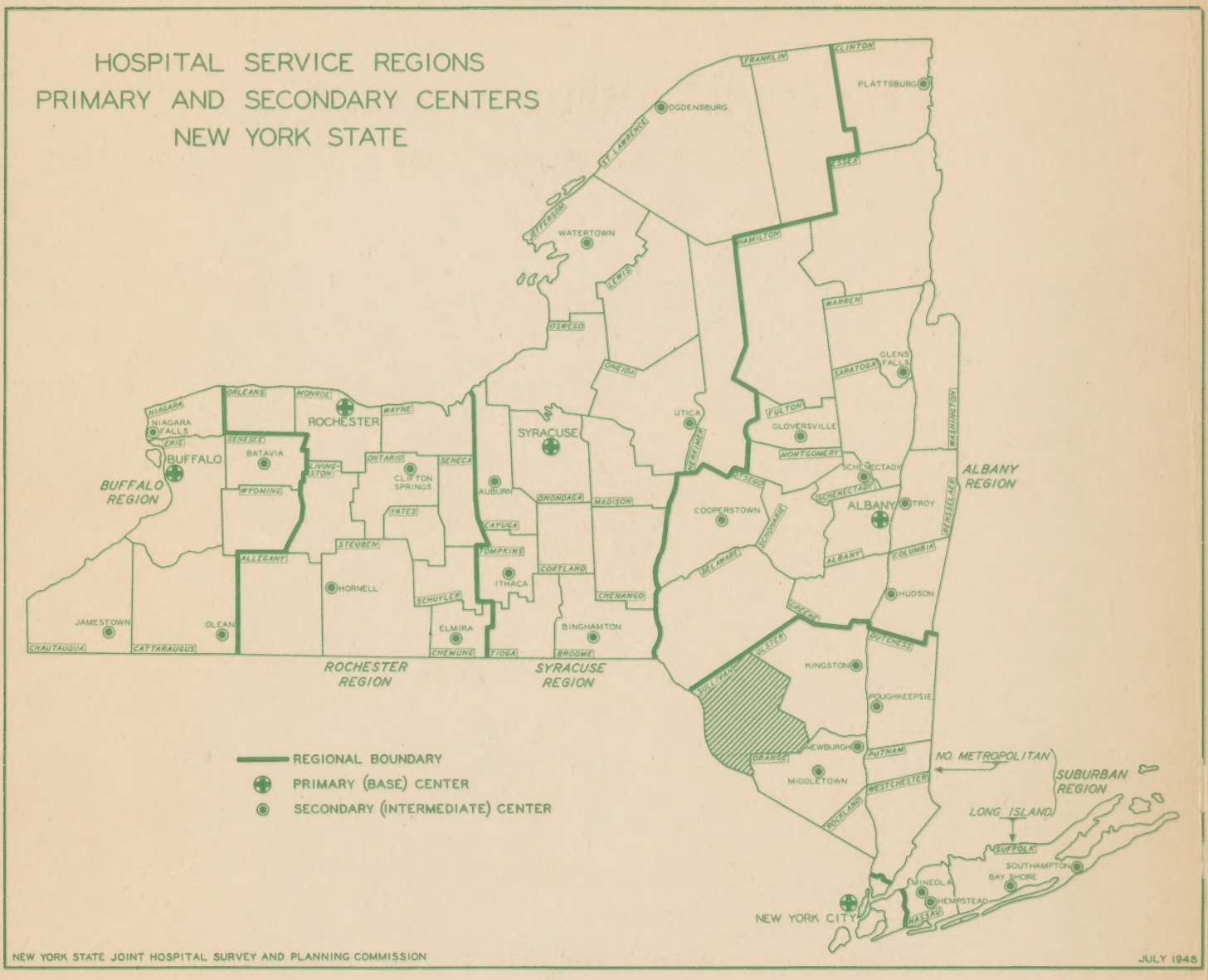
PLANNING HOSPITAL SERVICES

SULLIVAN COUNTY




HOSPITAL SERVICE REGIONS
PRIMARY AND SECONDARY CENTERS
NEW YORK STATE
FRANKLIN
CLINTON
PLATTSBURG
OGDENSBURG
ST. LAWRENCE
ESSEX
JEFFERSON
WATERTOWN
HAMILTON
LEWIS
WARREN
OSWEGO
ONEIDA
SARATOGA
GLENS FALLS
NIAGARA
ORLEANS
MONROE
ROCHESTER
WAYNE
SYRACUSE
UTICA
FULTON
WASHINGTON
NIAGARA FALLS
ERIE
BUFFALO
GENESEE
BATAVIA
LIVINGSTON
ONTARIO
SENECA
CLIFTON SPRINGS
AUBURN
GLOVERSVILLE
MONTGOMERY
SCHENECTADY
WYOMING
ONONDAGA
MADISON
HERKIMER
OTSEGO
ALBANY REGION
BUFFALO REGION
YATES
CAYUGA
COOPERSTOWN
SCHOHARIE
ALBANY
TROY
RENSSELAER
STEUBEN
TOMPKINS
CORTLAND
DELAWARE
COLUMBIA
ALLEGANY
HORNELL
ITHACA
SCHUYLER
CHENANGO
HUDSON
GREENE
JAMESTOWN
OLEAN
ELMIRA
BINGHAMTON
CHAUTAUQUA
CATTARAUGUS
CHEMUNG
TIOGA
BROOME
ROCHESTER REGION
SYRACUSE REGION
ULSTER
DUTCHESS
KINGSTON
SULLIVAN
POUGHKEEPSIE
NEWBURGH
PUTNAM
NO. METROPOLITAN
SUBURBAN REGION
ORANGE
MIDDLETOWN
WESTCHESTER
LONG ISLAND
ROCKLAND
SUFFOLK
SOUTHAMPTON
BAY SHORE
MINEOLA
HEMPSTEAD
NASSAU
NEW YORK CITY
REGIONAL BOUNDARY
PRIMARY (BASE) CENTER
SECONDARY (INTERMEDIATE) CENTER
NEW YORK STATE JOINT HOSPITAL SURVEY AND PLANNING COMMISSION
JULY 1948

PLANNING HOSPITAL SERVICES

SULLIVAN COUNTY, NEW YORK

A review of existing and needed hospital facilities and recommendations for future planning in Sullivan County, New York.

New York State Joint Hospital Survey and Planning Commission
in cooperation with
Northern Metropolitan Regional Hospital Planning Council

March 1949

For additional copies of this report, write

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* Chairman of State Advisory Council and participant in all meetings of the Commission, but not a member thereof by statute.

CONTENTS

FOREWORD

This report is submitted to the Board of Supervisors and to the Medical Society of Sullivan County in response to a resolution of the Board requesting the New York State Joint Hospital Survey and Planning Commission to study the current hospital situation in the County, make recommendations for future planning and file the findings with these two bodies.

The data have been assembled from information officially filed by the local hospitals participating in the statewide survey in 1946, additional facts more recently requested from these hospitals, discussions of the Commission staff with many informed persons and numerous published documents. The text and recommendations have been subjected to the criticism of and have been edited by interested local persons, the Northern Metropolitan Regional Hospital Planning Council of the Commission and the State Department of Health.

Although written by the Commission, this report is the result of the cooperative effort of many persons. To these the Commission is deeply grateful.

In reviewing this report and appraising its recommendations, the reader is urged to be ever mindful that the State Department of Health will submit a report on the public health facilities and services of the County. Since each supplements the other, they should be considered an inextricable unit.

Sullivan County today is in an advantageous position to plan its hospital facilities and services wisely for the future. Although lacking any appreciable existing facilities suitable for long-term use, it is not encumbered by extensive recent hospital investments which have suddenly become outmoded, it is high on the priority list for federal grants-in-aid for hospital construction, and it is eligible for state aid for hospital construction and operation under County auspices.

The subsequent recommendations are suggestive and flexible, not final. However, they should be modified only after serious consideration based on facts and future trends, only after the effects of such modifications on the long-term health and economy of the County have been conclusively determined and fully understood.

HIGHLIGHTS

Sullivan County, located in southeastern New York State along the Pennsylvania border, is about 100 miles northwest of New York City. Approximately half the 38,000 population is employed, mostly on farms and in the trade and service industries catering to the large annual influx of vacationers. Both the net buying power per family and the per capita full valuation of taxable real property rank high among the counties of upstate New York. The hospital situation in the County is as follows:

1. Since the tuberculosis and mentally ill patients are cared for in state-operated hospitals, local need is confined to facilities for the acutely and chronically ill. None of the four hospitals now serving the County is approved by the American College of Surgeons and, although they have a combined capacity of 94 beds, only 20 are suitable for long-range planning. The latter are all at Monticello Hospital, the only one originally built for hospital purposes. There is neither a county health department nor organized facilities for those chronically ill requiring hospitalization.

2. It is estimated that the County needs 190 additional general and 65 new chronic hospital beds to serve its residents and stem the current tendency for many to seek hospital care outside the County.

3. Any hospital planning in the County should provide high quality care consistent with current trends, i.e., (a) prompt and complete preventive, diagnostic and rehabilitation services for both the acutely and chronically ill; (b) properly equipped hospitals and public health centers as professional centers for physicians and public health personnel; (c) a flow of specialist services to these hospitals from larger neighboring hospitals and medical teaching centers; and (d) referral of local patients to such hospitals and centers when their medical conditions require types of care not available locally.

4. The new facilities recommended for the County are as follows:

   Phase I. Expansion of Monticello Hospital, under voluntary auspices, from 20 to 52 beds and addition thereto of a county-sponsored branch public health center. Replacement of Maimonides Hospital at Liberty with a 100-bed county state-aided general hospital, a 50-bed chronic wing and a main public health center.

   Phase II. Construction of 58 additional general and 15 chronic beds at either of the above hospitals, or distributed between the two, or at a new hospital in the northwestern part of the County which would function as a branch of the hospital at Liberty, as proposed in Phase I.

5. The total cost of Phase I is estimated at $1,957,000 and Phase II at $511,000. The local share would range between one-third and two-thirds of this cost, depending upon whether or not any or all of the facilities were under County auspices and state aided. The remainder of the capital funds would be available from federal or federal and State sources.

6. A representative non-official Sullivan County Hospital Council should be formed to study and discuss these recommendations and promote proper long-range planning in the County.

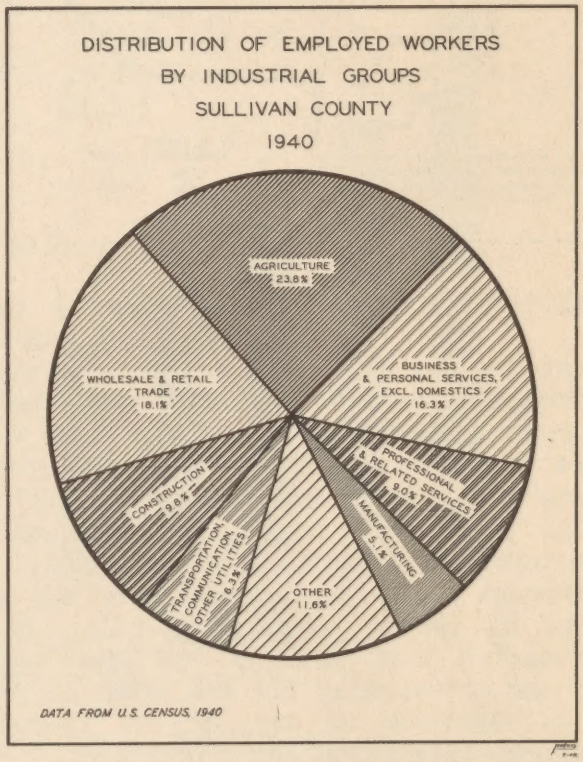
BACKGROUND

HISTORY AND GEOGRAPHY

Sullivan County, named for General John Sullivan of Revolutionary fame, is located in the southeastern part of New York State, along the Pennsylvania boundary, and on the periphery of the New York City Metropolitan Area, less than 100 miles from that City by road. Founded in 1812 from part of Ulster County, one of the original ten of the State, Sullivan was the forty-fifth of the 62 counties to be established in New York. Now, as then, the County seat is at Monticello. Although traversed by several railroads along its borders, transportation to and within the County is generally by automobile and bus. The County, approximately 40 miles long and 35 miles wide, has two-fifths of its 986 square mile area in farms. Much of the remainder is interlaced with the fishing lakes, streams and Shawangunk Mountains which beckon vacationers the year round.

EMPLOYMENT

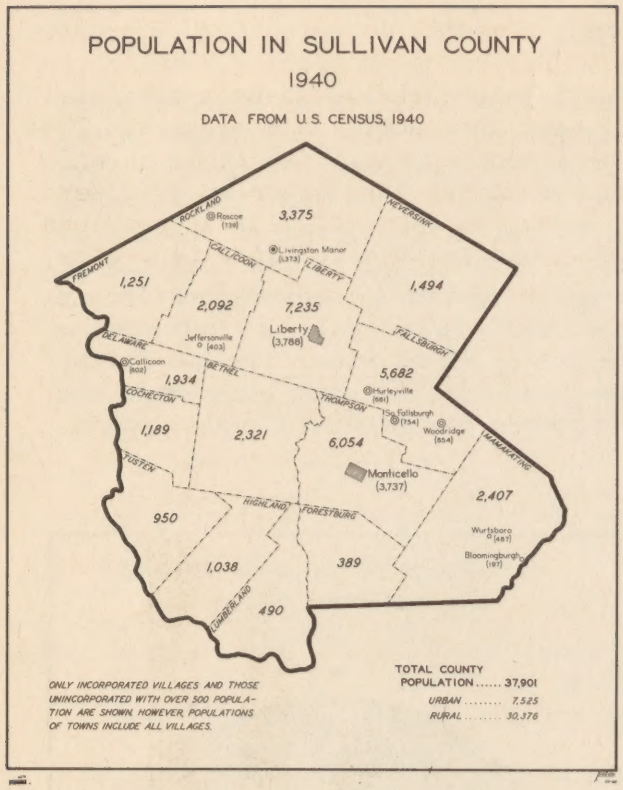
In 1940 slightly less than half the population was employed, one-quarter on farms -- mainly dairy, poultry and livestock farms -- and the rest in trade and service industries. The economy of the County reflects its major industry -- catering to the needs of an enormous annual number of vacationers. Raising food; operating hotels, restaurants and boarding homes; providing bus and taxi transportation; maintaining shops, banks, filling stations, laundries and cleaning establishments -- all these, and others too, are the bulwark of local earned income. Comparatively speaking, manufacturing is negligible, a factor which mitigated against any appreciable conversion to war production during World War II.



These sources of livelihood have served the residents well. In 1947 Sullivan County had a net buying power of $5,566 per family and ranked third among the 57 upstate counties, exceeded only by Westchester and Nassau Counties, respectively. 1/ Similarly, in 1948, the per capita full valuation of taxable real property of $2,591 placed the County in third position among upstate counties, outranked only by Putnam and Westchester Counties, in the order named. 2/

1/ Data from Sales Management (Survey of Buying Power Issue), May 10, 1948, p. 174 ff.

2/ Computed on basis of (a) "State Equalization Table for the Year 1948," published by the New York State Tax Commission, p. 156; and (b) county population estimated by the State Department of Health, as of July 1, 1948.

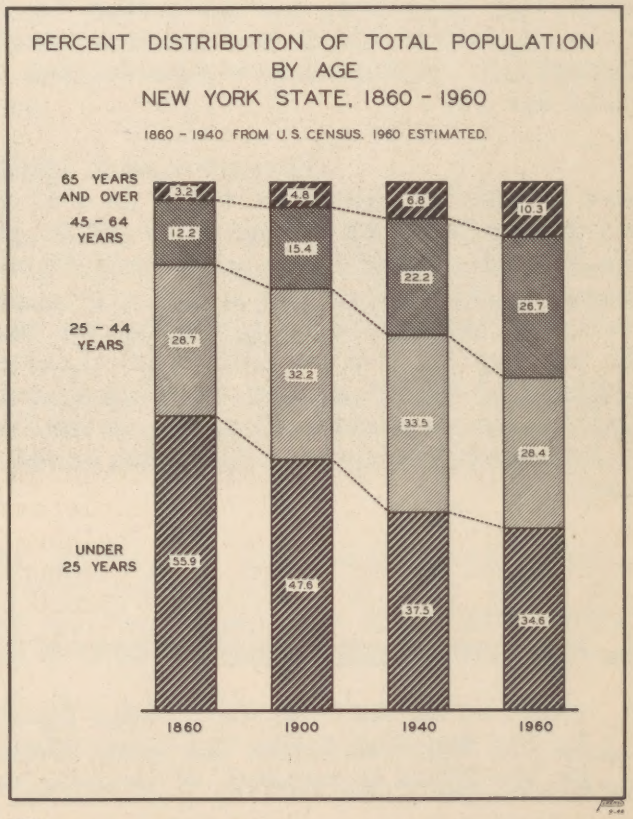


POPULATION Although increasing gradually from 25,000 in 1850 to 38,000 in 1940, the population of the County changes little from year to year and decade to decade, is almost entirely white and predominantly native born. 3/ Inhabitants are concentrated around the larger villages of Liberty and Monticello and in the eastern section of the County, with relatively few in the towns along the Pennsylvania border.

Yet, although changing little in number, the County population is aging, like that of New York State as a whole. In 1860 well over four-fifths of the State population was under 45 years old -- the years of schooling, active physical activity, maximum production and child-bearing -- while only three per cent was over 65 years of age. However, by 1960 the proportion of this younger age group will have decreased woefully and that of the older tripled.

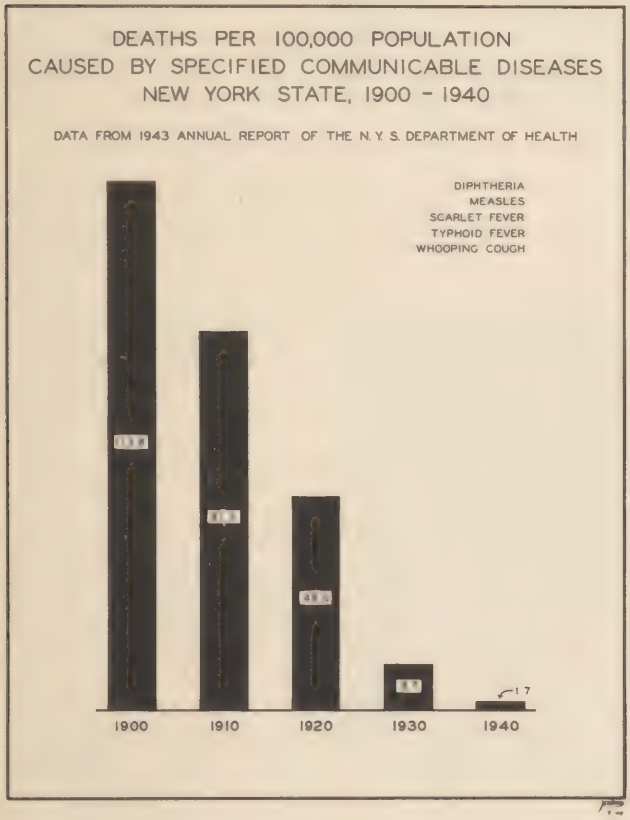
HEALTH STATUS This tendency foreshadows problems that must be met and solved. Economically, productive man-power will decrease unless current trends are reversed and older workers are freely eligible for employment. Medically, the problem of chronic illness will increase. In this connection, two factors merit particular attention: (1) Although a greater proportion of the aged tend to become chronically ill, it is estimated that half of the total number of the chronically ill are under 45 years old. Needless to say, all of these are neither incapacitated nor bedridden. Many are ambulant and employable but require adequate medical care to prevent forced inactivity. (2) The trend toward chronic illness and incapacity can, and should, be reversed. Early and prompt diagnoses of high quality and proper and continuing treatment can allay the ravages of the insidious, barely discernible onset; and application of the new methods of rehabilitation can salvage many victims for a productive, useful and happy life.

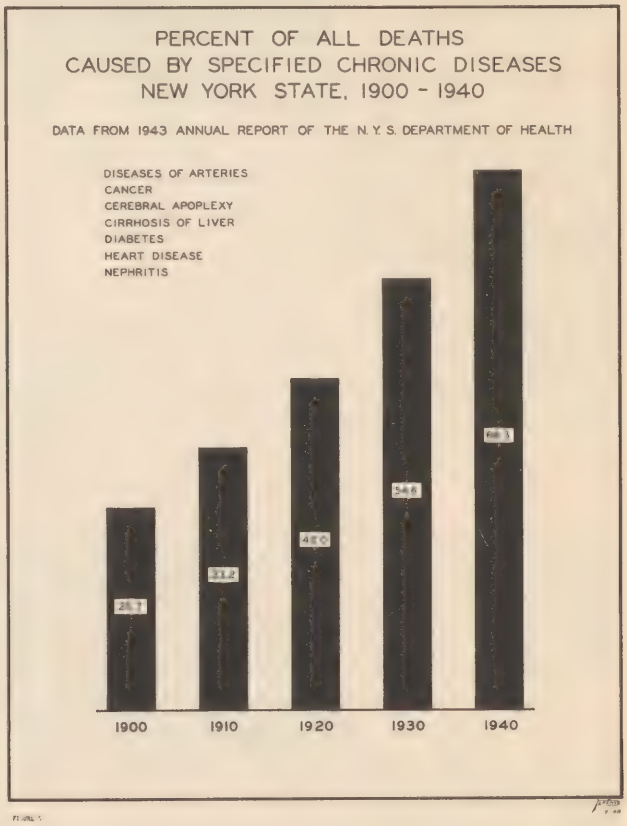
Other trends are also emerging. Deaths from communicable disease have been



3/ U.S. Census

drastically reduced through immunization, isolation, adequate case-finding, improved methods of treatment and the vigilance and zeal of practicing physicians, health officers and hospitals. Children, as well as adults, have been saved from the fatal scourges of the last century, preserved to live to full maturity and old age. The death rate for infants is but a third of that of a half century ago. Yet those chronic diseases which caused only one-quarter of all deaths in New York State in 1900 were responsible for two-thirds of the total in 1940. Thus, the types of medical problems are shifting from those of dramatic epidemics and youth to those of long-term care, rehabilitation and age.





EXISTING HOSPITAL FACILITIES

There are four general types of hospital patients: The tuberculous, the nervous and mentally ill, the acutely ill and the chronically ill. Sullivan County usually hospitalizes its tuberculosis patients in the state-operated Homer Folks Hospital at Oneonta, its mentally ill at Middletown State Hospital, its acutely ill in the general hospitals of Sullivan and neighboring counties, and its chronically ill in the county public home infirmary, local nursing homes and, sometimes, in its general hospitals. Therefore, this report deals only with the hospital needs of the acutely and chronically ill as these facilities are a local responsibility.

General hospitals. The four general hospitals in the County, with a combined capacity of 94 beds, have only 20 which are considered suitable for long-range, modern hospital planning. With the exception of Monticello Hospital, each is housed in a converted private dwelling not originally built for hospital purposes, is nonfire-resistive and is too small for either economical operation or for the development of a modern, balanced medical staff. (See Table, page 6.)

General Hospitals Located in Sullivan County

Hospital	Location	Sponsorship	Capacity (Beds) a/	Per Cent Occupancy (1945) b/
Total	--	--	94	--
Callicoon Hospital	Callicoon	Proprietary	14	61
Hamilton Avenue Hospital	Monticello	Proprietary	25	79
Maimonides Hospital	Liberty	Nonprofit	35	48
Monticello Hospital	Monticello	Nonprofit	20	111

a/ As reported to the State Joint Hospital Survey and Planning Commission by the respective hospitals in 1946.

b/ "Capacity" indicates the number of beds which a hospital has been built to accommodate. It should not be confused with "complement", the number of beds which a hospital may actually have set up, often by placing two beds in a room intended for one, by using corridors, porches, etc.

Local newspapers have reported that the American College of Surgeons, which evaluates hospitals annually on the basis of such factors as physical plant, board and staff organization and medical records, has not approved any of these hospitals and that the nearest ones approved are at Port Jervis, Poughkeepsie, Kingston and Middletown. 4/

The need for more adequate hospital accommodations in the County is self-evident. All are experiencing an increased demand, generally during the summer with its influx of vacationers. For example, the occupancy rate at Maimonides Hospital reached 89 per cent in July 1947 and 82 per cent in July 1948 and that at Monticello Hospital 142 per cent in August 1947 and 134 per cent in July 1948. When one considers that a 75 per cent occupancy rate in hospitals of this size represents a saturation point, the burden upon these hospitals is conclusive. And, even then, many residents are patronizing hospitals in neighboring communities rather than those closer to home.

Facilities for the chronically ill. Today, because there are no modern, organized hospital facilities for the chronically ill in the County, such patients are cared for in the 60-bed county public home, the 24 beds in four nursing homes 5/ and 70 beds for the nontuberculous at the Recreation Farm at Fosterdale. However, since the latter is intended primarily for members of the Workmen's Benefit Fund, living

4/ Liberty Register, Jan. 29, 1948, and Monticello Republican, Feb. 1, 1948.

5/ Anderson Nursing Home at Jeffersonville, 3 beds; Grand View Nursing Home at Rockland, 12 beds; Haddon Nursing Home at Woodbourne, 2 beds; and McCormick Cottage at Liberty, 8 beds.

HAMILTON AVENUE HOSPITAL — MONTICELLO

CALLICOON HOSPITAL — CALLICOON

MAIMONIDES HOSPITAL — LIBERTY

within as well as outside the County, it cannot be regarded solely as a local institution. In brief, facilities for the proper hospital care of the chronically ill are nonexistent, but greatly needed.

HOSPITAL CARE OF TOMORROW

TRENDS

Prompt, adequate and complete medical care is three-fold: The prevention of disease, diagnosis and treatment of ill persons and rehabilitation of the handicapped. This can be achieved only when the general practitioner, who is the key person in providing care to the individual and his family, cooperates with public health officials to prevent disease, when the center of his professional activities is a well-planned general hospital, when rehabilitation services of a high quality are readily available. The gap between preventive and curative medicine is closing. Public health is not solely concerned with promoting proper sanitation, safeguarding food and water supplies, encouraging immunization, enforcing quarantine and collecting vital statistics. It is equally interested in the individual, as shown by its intensified programs of public health education, early case finding of cancer cases and treatment of child orthopedic cases.

ROLE OF THE GENERAL HOSPITAL

Facilities and services cannot be dissociated, for neither can operate fully without the other. Facilities are needed to make services effective and facilities without services are valueless. Hospital beds alone will never ensure improved health. Personal effort, as well as teamwork among qualified medical, nursing and public health personnel, is needed. This can best be encouraged by housing the local full-time health department in a health center unit conceived as a wing of the general hospital. Similarly, an adequate laboratory, requisite to the scientific practice of medicine and public health, should also be a part of the general hospital and should serve the health department and practicing physicians, as well as the hospital.

Such a general hospital-laboratory-public health center facility must be properly planned to be creditable. For example, a hospital must be large enough to operate economically, for larger hospitals can operate at higher occupancy rates than smaller ones, especially if the latter are to have the reserve beds needed for emergencies and seasonal increases in illness. Also, larger hospitals are better able to attract competent personnel, warrant the establishment of an organized staff and justify the organization of basic medical specialties. Careful study of hospital operating costs has shown that, as their capacities decrease below 100 beds, the maintenance of a balanced staff of medical specialists becomes increasingly difficult and expensive, a factor reflected in the daily charge to patients, or in the operating deficit.

REVERSING THE TREND

Today, the highly specialized diagnostic and specialist services, concentrated at urban medical centers, are attracting patients from the less populous communities, usually those best able to pay for care. Thus, local hospitals are left with an increasing proportion of part-pay and indigent patients 6/, an unstable fiscal situation. Similarly, many well-trained physicians are locating near teaching-type hospitals, largely in populous urban areas, where specialized diagnostic and consultative services, newly developed

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6/ Hospital care of indigent patients is a public responsibility, usually paid for with tax funds.

therapeutic facilities and professional opportunities abound. Therefore, if long-range planning is to provide improved care successfully in less populous areas, this course must be stemmed and partially reversed. Failure of community hospitals to offer some of the enticements now luring physicians to medical centers will further isolate these areas from the benefits of high quality, modern medical care.

AFFILIATION OF HOSPITALS

To ensure the proper location of hospitals and promote a flow of high quality services among neighboring hospitals of various sizes and competency, the New York State Joint Hospital Survey and Planning Commission has developed a hospital plan for the State. This is not a mandatory governmental formula, but an optional and flexible blueprint, an adaptable pattern.

For planning purposes, the State has been divided into seven hospital service regions, each of which is composed of a number of counties. (See map, front cover.) Sullivan County is in the Northern Metropolitan Region. Although political boundaries ideally should be disregarded in the development of such hospital service areas, county lines were adopted as boundaries because of their realism and for statistical and legal reasons. However, such lines should not and will not influence or restrict the flow of patients seeking hospital care. Each region will be served by three types of general hospitals:

> Primary centers should have one or more hospitals of at least 200-bed capacity, medical teaching institutions providing diagnostic and treatment facilities in all the specialties, programs for undergraduate and graduate medical and nursing education, and facilities for research. (The primary center for Sullivan County would be New York City.)
>
> Secondary centers should have one or more hospitals of at least 100-bed capacity, with organized medical departments under competent direction in the basic specialties of general surgery; internal medicine; obstetrics and gynecology; pediatrics; eye, ear, nose and throat; pathology; and radiology. (The secondary centers for Sullivan County would be Kingston, Poughkeepsie, Newburgh and Middletown.)
>
> Community hospitals in other than primary and secondary centers would have a minimum capacity of 50 beds, qualified local specialist services in at least general surgery and internal medicine, and an affiliation with a neighboring secondary or primary center for providing the other basic specialties. (All general hospitals in Sullivan County would be community hospitals.)

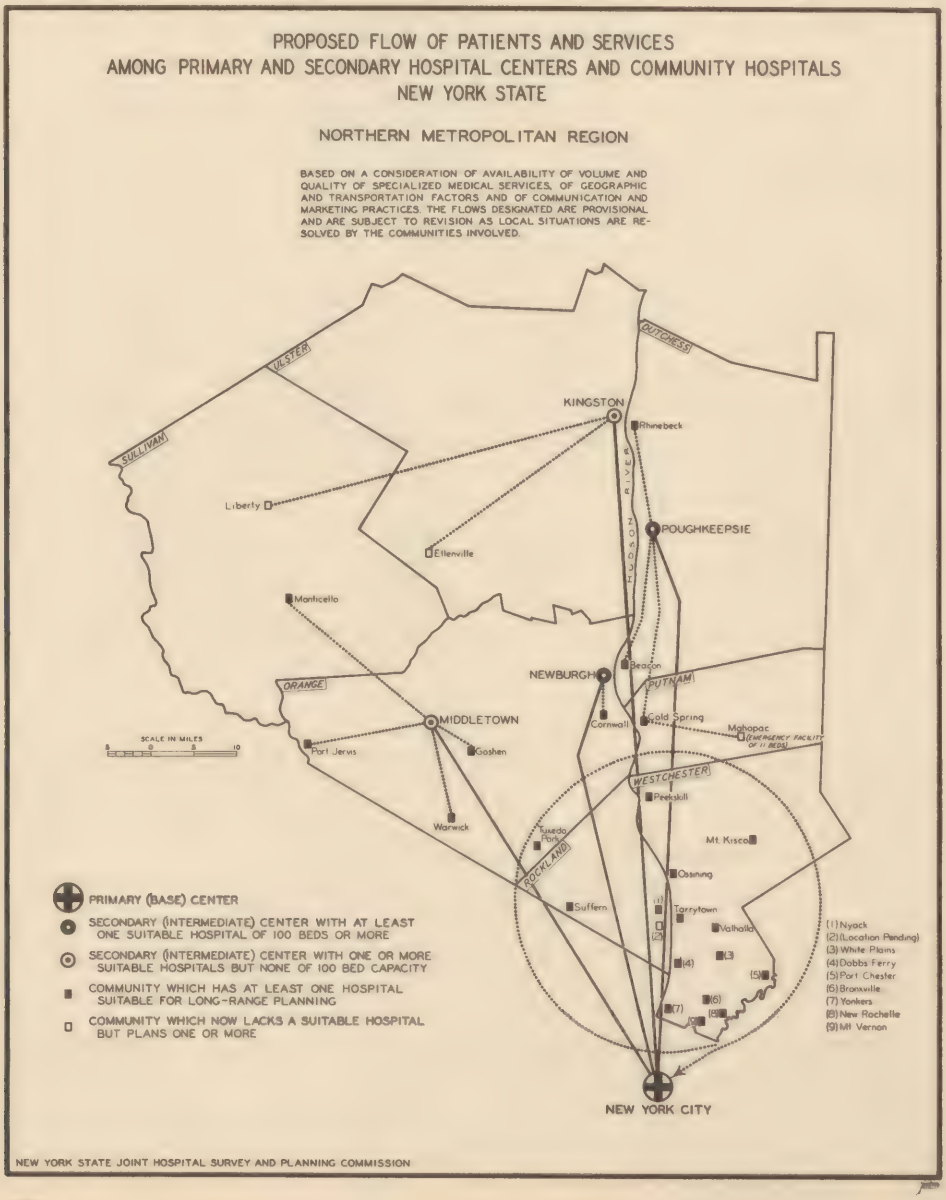
To ensure access to needed specialized services for nonurban areas, such as Sullivan County, the plan envisages an affiliation among hospitals of various sizes. This involves a two-way flow: (1) The flow of professional personnel and special services from the primary and secondary center hospitals to the community hospitals and (2) The flow of patients and records from the community hospitals to the centers.

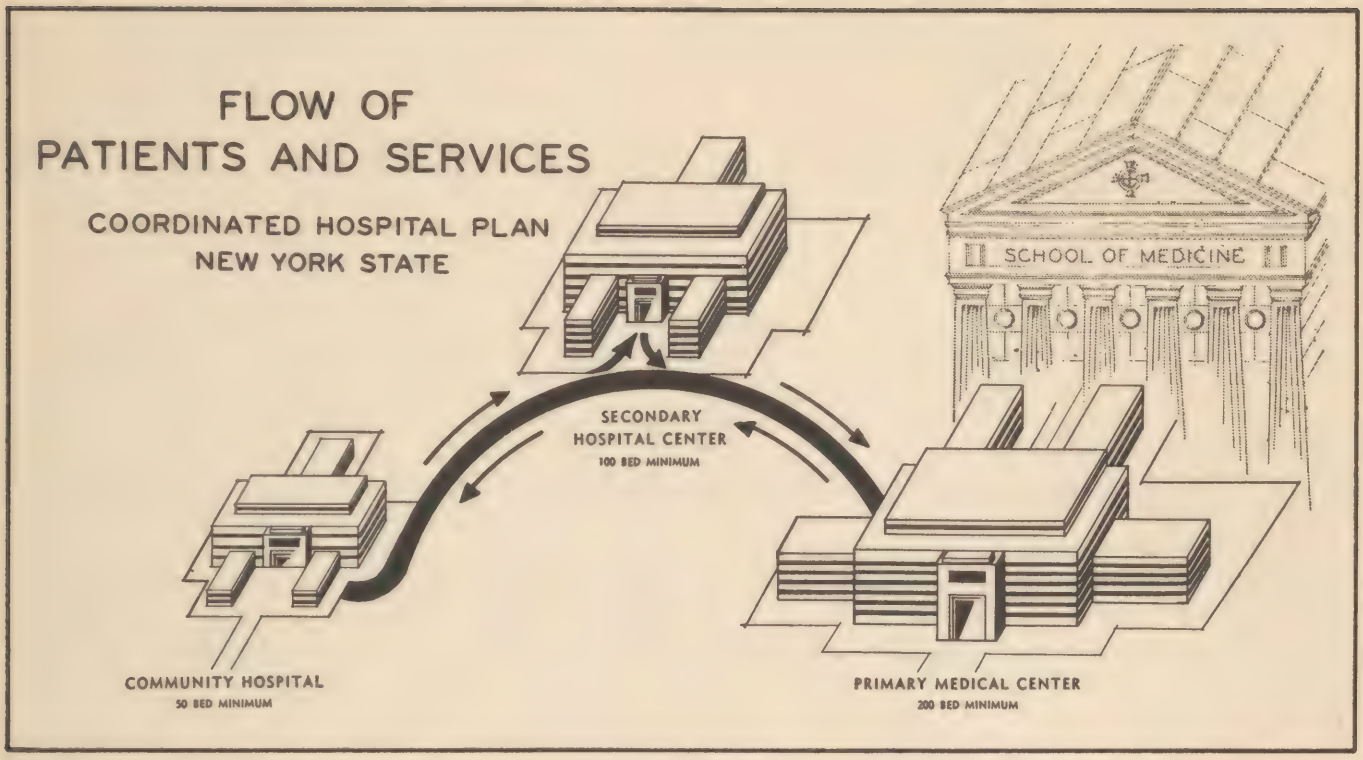
Services from such centers to hospitals in Sullivan County would be of two kinds, (1) Serviees to the hospital as a whole and (2) services to particular patients. The former would consist of regularly scheduled conferences on X rays, review of problem medical cases and advice on hospital administration and nursing care. Expenditures for such services might well be included in the total operating cost of the hospital as part of the general overhead and reflected in the per diem charge to patients. On the other hand, consultation on a particular case might be secured, as needed, with the charge based on an established fee schedule and paid by the individual patient concerned.

Conversely, patients from Sullivan County might be referred to neighboring centers when, after consultation, it is concluded that they require care in larger hospitals for such services as brain and certain radical cancer surgery, psychiatric examinations and plastic surgery.

Sullivan County is prolifically interlaced with highways. All lead to one or more secondary centers -- Middletown less than 15 miles from the lower part of the County, Newburgh but 27 miles from the east boundary and Kingston and Poughkeepsie less than 50 miles. The primary centers at New York City and Albany are 100 miles away. Since people journey long distances to shop for major items, it seems reasonable to assume that they would be willing to travel equally far for those highly specialized medical services, not locally available, which often spell the difference between health and invalidism. (See map, back cover.)

It is believed that such a mechanism is the key to reversing the trend, the method for bringing the technical benefits and experience of larger hospitals to those of more modest size, the means for inducing physicians to locate in the villages and smaller cities.





FACILITIES NEEDED

VOLUME OF FACILITIES

It is estimated that 210 general hospital beds 7/ are required to provide adequate hospital care within the County itself for both residents and visitors. Since there are now only 20 beds suitable for long-range planning, 190 more general hospital beds will be needed ultimately. Another 65 beds 8/ are needed for those chronically ill primarily requiring continuous, active medical and professional nursing care, exclusive of those needing only custodial and attendant service under medical and nursing supervision. The latter might best be cared for in high quality, proprietary nursing homes or in an adequately equipped and staffed public home infirmary.

Furthermore, if the County establishes a county health department, it would also require a main public health center, including laboratory space, and branches thereof, as needed.

7/ Estimated on basis of the birth-death bed ratio which relates hospital needs to the number of births and deaths occurring among residents of the County. Allowances have been made for seasonal fluctuations and abnormal demands.

8/ Estimated on the basis of two (2) beds per 1000 population, adjusted to allow for referral of selected patients to medical centers, as needed.

A UNIFIED APPROACH

These services should all be housed together in one inclusive building serving a specific, prescribed area. It would be the locale for the medical specialties and nursing skills of the area served, the base for dissemination of professional knowledge, the common ground for improving working relationships among practicing physicians and nurses and public health personnel -- the professional center for all. It would become the community's instrumentality for an all-out offensive for good health and would concentrate and unify medical and nursing manpower, equipment and services, just as in any successful business or research enterprise.

FACTORS TO BE CONSIDERED

There are sound reasons for caring for both the acutely and chronically ill in the same hospital, preferably in different wings. A practicing physician could simultaneously visit both types among his patients on the same hospital call; the specialists on the hospital staff would be equally available to the chronically and acutely ill; the facilities needed by both kinds of patients, such as operating rooms, kitchens, sterilizing equipment and heating plants, could be used in common, not duplicated. Furthermore, if demand for general care should decrease and that for chronic care increase, as seems possible, the general beds could readily be assigned for use of chronic patients. But, if this shift in demand were to occur in a community with separate general and chronic facilities, the usage of one would decrease, the demand on the other become overwhelming, and reassignment of beds impossible. This would be poor economy.

On the basis of experience of hospitals of various sizes, it seems advisable to plan for one-third of the beds on private, one-third on semi-private and one-third on a ward basis. However, it should be noted that, although the gross per diem cost for the chronically ill should be somewhat lower than that for the acutely ill, service to the former will be for longer periods and to fewer patients personally able to pay for care.

STATUS OF PRESENT PLANNING

Although several possibilities have been suggested for increasing the number of hospital beds in Sullivan County, four have received appreciable consideration, as follows:

1. Expansion of the Monticello Hospital from 20 to 52 beds by remodeling the solaria of the present structure to accommodate 10 beds and adding a new 22-bed wing. (Subsequently a local news item reported merely the addition of a 25-bed wing to cost $125,000. 9/) Although the hospital filed and the State Hospital Planning Commission approved (November 1948) the application for federal grants-in-aid to cover one-third the cost of the improvements described, the sponsor subsequently withdrew the application because of inability to raise the local share of the total cost.

2. The County plans to replace its present public home with a new 100-bed plant (50 infirmary and 50 noninfirmary beds) at an estimated cost of $308,660. 10/ However, since a majority of the potential inmates of this envisaged institution will be chronically ill persons, it is suggested that the County give serious consideration to constructing this unit as a wing of the general hospital proposed on page 13.

9/ Monticello Evening News, Dec. 10, 1948.

10/ New York State Postwar Public Works Planning Commission, Final Report, March 1947, p. 128.

3. Conversion of a portion of the Loomis Sanatorium near Liberty into a general hospital. Only one of the 45 structures on this tract is of modern steel and masonry construction, completely fire-resistive and suitable for long-range planning. Both the architect and engineer of the State Hospital Commission are of the opinion that such a conversion would be too costly, could never provide efficient service and would become "a lifetime liability".

4. At one time, local interests were considering converting an abandoned school building near Liberty to hospital purposes, but this structure, reportedly, has now been purchased by private interests, obviating this possibility. Moreover, the comments made previously relative to the conversion of the Loomis Sanatorium are equally applicable to the school.

Therefore, with the exception of the proposed expansion of Monticello Hospital, these suggestions do not seem feasible for long-range hospital planning.

RECOMMENDED PLAN Because of the urgent need for general hospital beds, the disadvantages inherent in converting the foregoing structures to hospital use, the advisability of providing modern medical and hospital services within the County itself and the responsibility for ensuring economical and efficient service of high quality, the State Hospital Commission respectfully suggests the following long-term plan for Sullivan County.

First Phase

1. Consummation of the current plans for the expansion of the Monticello Hospital from 20 to 52 beds.

2. Construction of a branch county public health center, including laboratory facilities, as a unit of the Monticello Hospital.

3. Replacement of the present Maimonides Hospital with a county state-aided 100-bed general hospital and a 50-bed chronic wing.

   Note: If the County officials support this proposal, the Maimonides Hospital, now under voluntary nonprofit auspices, may be willing to turn over to the County its entire plant and equipment and assign its assets and $100,000 now in hand as the nucleus of an endowment fund to be administered by a voluntary citizens' organization charged with the responsibility of promoting interest in the proper operation of the potential hospital.

4. Construction of a main county public health center, including laboratory facilities, as a unit of the county state-aided hospital proposed in #3, immediately above.

Second Phase

5. Upon completion of Phase I, the hospitals at Monticello and Liberty would have 152 general and 50 chronic beds, as compared with the estimated 210 general and 65 chronic beds needed. A deficit of 58 general and 15 chronic beds would remain. Therefore, the purpose of the second phase of construction would be to absorb this bed deficit.

However, such future expansion should not be considered until (a) there is a demonstrated and verified demand for additional facilities; and (b) the quality, effectiveness and efficiency of the service provided by the then existing hospitals are commensurate with those standards which hospitals of such size are adjudged capable of attaining.

Such an expansion (58 general and 15 chronic beds) could best be achieved in one of two ways: (a) Addition of beds to either or both the existing hospital at Monticello or the one proposed at Liberty or (b) the construction of a county state-aided hospital and public health center, possibly in the northwestern part of the County, as branches of the proposed county hospital and public health center at Liberty.

In the event that the expansion plans of Monticello Hospital, now under voluntary non-profit auspices, fail to materialize, consideration should be given to the County taking over and expanding this plant as a branch of the proposed county state-aided hospital at Liberty.

MEETING THE COST

COST OF CONSTRUCTION — The uncertain costs of labor and material make it difficult to present an accurate estimate of construction costs. Similarly, the fluctuation of wages, costs of supplies and food, the decreasing average length of hospital stay per patient and the varying occupancy rates among hospitals preclude estimates of per diem operational costs. With these reservations, the data in the table on page 15 are presented as a guide to planning.

SOURCES OF FUNDS — The potential sources of capital funds for hospital construction in Sullivan County are as follows:

Local funds, public and private. If it continues under voluntary auspices, the local share (two-thirds of the total) for financing any expansion of Monticello Hospital must come from private contributions. On the other hand, county tax monies can constitute the local share for construction of any facilities under county auspices, such as the proposed health centers and replacement of Maimonides Hospital with a county hospital. The county share would amount to one-third of the total cost if the acility is state-aided, and two-thirds of the total if not state-aided.

The amount of such a county capital expenditure could be decreased in several ways: (1) A citizens' committee might conduct a drive for voluntary contributions to be turned over to the County for application toward the construction cost. (2) The County might avail itself of any willingness of the Maimonides Hospital to turn over its plant and equipment to the County, as noted on page 13. (3) Any funds which the County has set aside for replacing the existing public home might be reallocated toward construction of the chronic wing of the proposed county hospital. (It should be noted that neither State or federal funds toward capital construction costs nor state aid funds toward

Summary of Estimated Construction Costs of Proposed Hospital Projects, Sullivan County

Description of Project	Estimated	
	Sq. Ft.	Cost a/
Phase I		
1. Monticello Hospital - renovation providing for 10-bed expansion, addition of new 22-bed wing.	--	$ 348,826
2. Branch public health center, including branch laboratory, at Monticello Hospital.	1,000	18,000
3. New hospital at Liberty		
(a) 100-bed county state-aided general hospital, including such central service facilities as operating and delivery rooms, power plant, kitchen, storage facilities, administrative offices, lounges	55,000	1,000,000
(b) 50-bed chronic disease wing which, although relying on the central service facilities described in #3(a), above, would include space for rehabilitation services, chapel, small dining room(s), lounges, etc.	27,500	500,000
4. Main public health center, including laboratory, as unit of proposed hospital at Liberty.	5,000	90,000
Phase II		
5. Construction of sufficient additional beds to meet the remaining estimated demand.		
(a) 58 general hospital beds	5,800 b/	406,000 b/
(b) 15 chronic disease beds	1,500 b/	105,000 b/

a/ Estimated cost of expansion of Monticello Hospital (item #1) is that reported by sponsor on his application for federal grants-in-aid, August 31, 1948. All other estimates have been made by the State Hospital Survey and Planning Commission at the rate of $10,000 per bed for new hospitals and $7,000 per bed for expansion of existing facilities.

b/ Estimates applicable only if beds are added to existing hospitals. If constructed as a new facility, both the square foot area and cost would be greater as central service facilities would also be needed.

Potential Sources of Funds for Construction of Proposed Hospital Projects, Sullivan County.

Recommended Construction	Auspices	Estimated Cost			
		Total	Sources of Funds		
			Local	Federal	State a/
Phase I					
1. Monticello Hospital: 10-bed expansion, 22-bed addition	Nonprofit assn.	$ 348,826	$232,511 b/	$116,275	--
2. Branch public health center at Monticello Hospital	County	18,000	6,000	6,000	$ 6,000
3. New county state-aided hospital at Liberty					
(a) 100-bed general hospital	County	1,000,000	333,334	333,333	333,333
(b) 50-bed chronic wing	County	500,000	166,667	166,667	166,666
4. Main public health center as a unit of proposed hospital at Liberty	County	90,000	30,000	30,000	30,000
Phase II					
5. Construction of sufficient additional facilities to meet the remaining estimated demand					
(a) 58 general beds	Nonprofit assn. and/or County	406,000 c/	135,334	135,333	135,333 d/
(b) 15 chronic disease beds		105,000 c/	35,000	35,000	35,000 d/

a/ If county operated facilities were not state-aided, all funds shown in this column would be included in the "local" column.

b/ If facility should be taken over and the expansion program consummated by the County, the local (County) share could be decreased to $116,276 if it were a State aided facility.

c/ Estimates applicable only if beds are added to existing hospitals. If constructed as a new facility, both the area and cost would be greater as central service facilities would also be needed.

d/ State funds available only for expansion of proposed county state-aided hospital at Liberty or for addition of county-owned wing to Monticello Hospital. If latter wing is under nonprofit auspices, State share, as shown, must come from local sources.

operating deficits are available for public homes and their infirmaries.)

Federal funds. Federal aid for hospital construction, administered in New York State by the Joint Hospital Survey and Planning Commission, amounts to one-third of the total cost of construction. It is granted on a priority basis of need of a county, in relation to the need of other counties in the State. Projects may receive both state and federal aid simultaneously if they comply with the eligibility requirements for both.

State funds. Counties under 50,000 population are eligible for state aid in the amount of 50 per cent of the county expenditure for the construction of official county general hospitals if (1) there is a demonstrable need for additional or improved hospital facilities; (2) the county has a full-time, organized county health department; and (3) such a department is housed in a public health center which is a unit of the hospital. 11/

With these sources of funds in mind, the proposed construction program might be financed as shown in the table on page 16.

PRIORITY RATING Sullivan County is seventh on the State priority list for federal grants-in-aid for hospital construction. If a county of high priority is unable to proceed with construction at the time federal aid is first offered, it will retain its original priority rating during the life of the hospital construction program. However, the availability of such aid will depend upon federal appropriations from year to year and the percentage thereof allocated to New York State. Therefore, such a priority may be invoked in a subsequent year when a sponsor within the priority area is ready to proceed, but consummation of such a project will depend upon availability of federal funds. (See chart, page 18.)

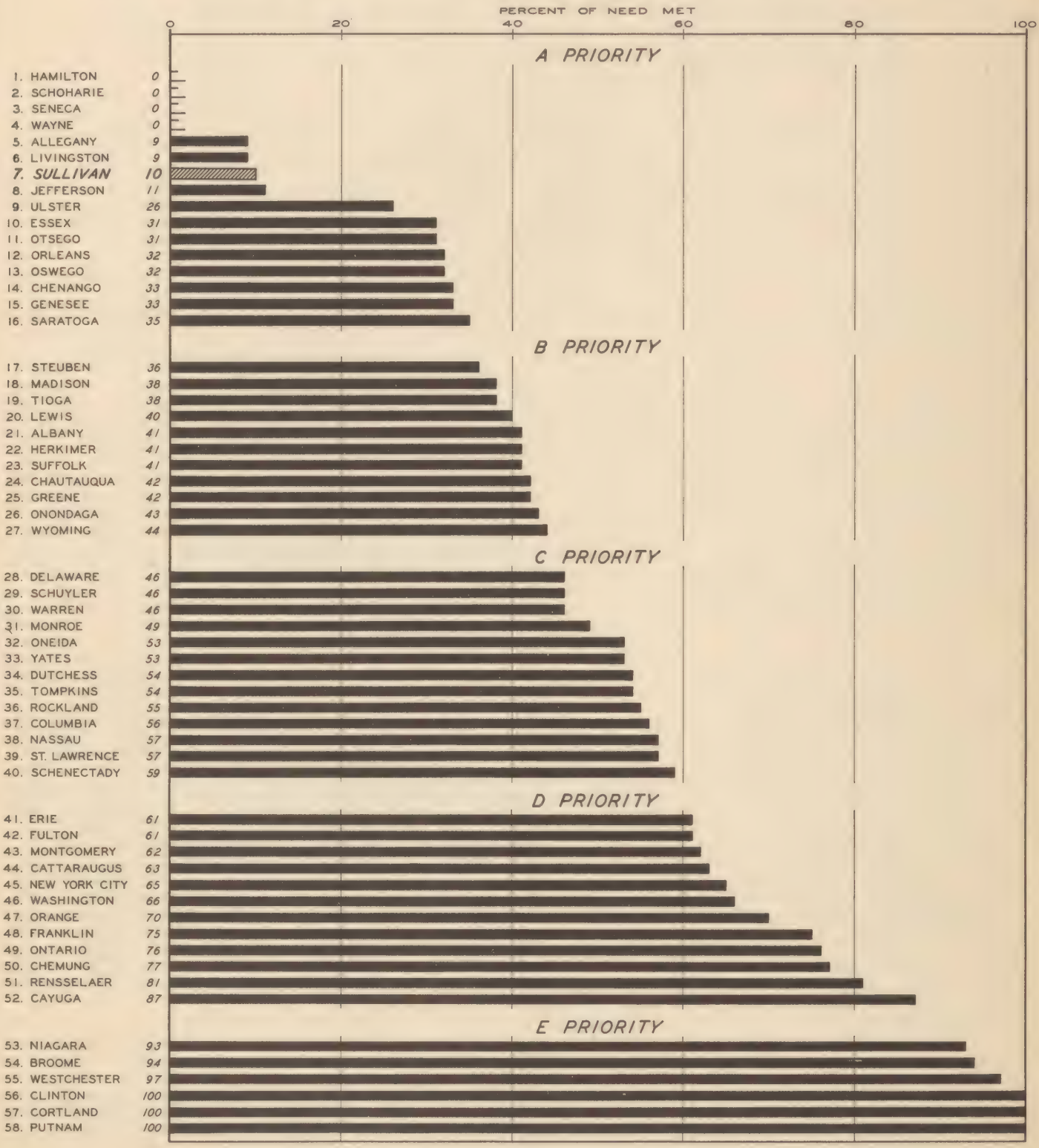
IN CONCLUSION

"Is it needed?" "Is it worth it?" These questions will, and should, be asked by individuals, business firms, granges, labor unions, churches, hospitals, professional organizations, hotel proprietors, the elected officials of Sullivan County and by every other citizen. Anything less would indicate poor judgment, improvidence and a lack of civic responsibility. In reply there is evidence, based on experience, that only properly planned, competently operated medical facilities can foster the optimum of health attainable, check the increasing migration of patients to neighboring medical centers and attract the younger, capable physicians. It is as much "good business" as it is the provision of needed services. Preventing sickness, curing the ill, rehabilitating the handicapped and controlling chronic illness are means of increasing productive manpower, restoring morale and promoting a happy and prosperous community life -- assets that attract visitors as well as permanent residents. Moreover, if both federal and state aid are sought, approximately only one-third of the funds must come from local sources -- and this with the retention of local autonomy. Thus the query resolves itself into: "Can we afford not to do it?"

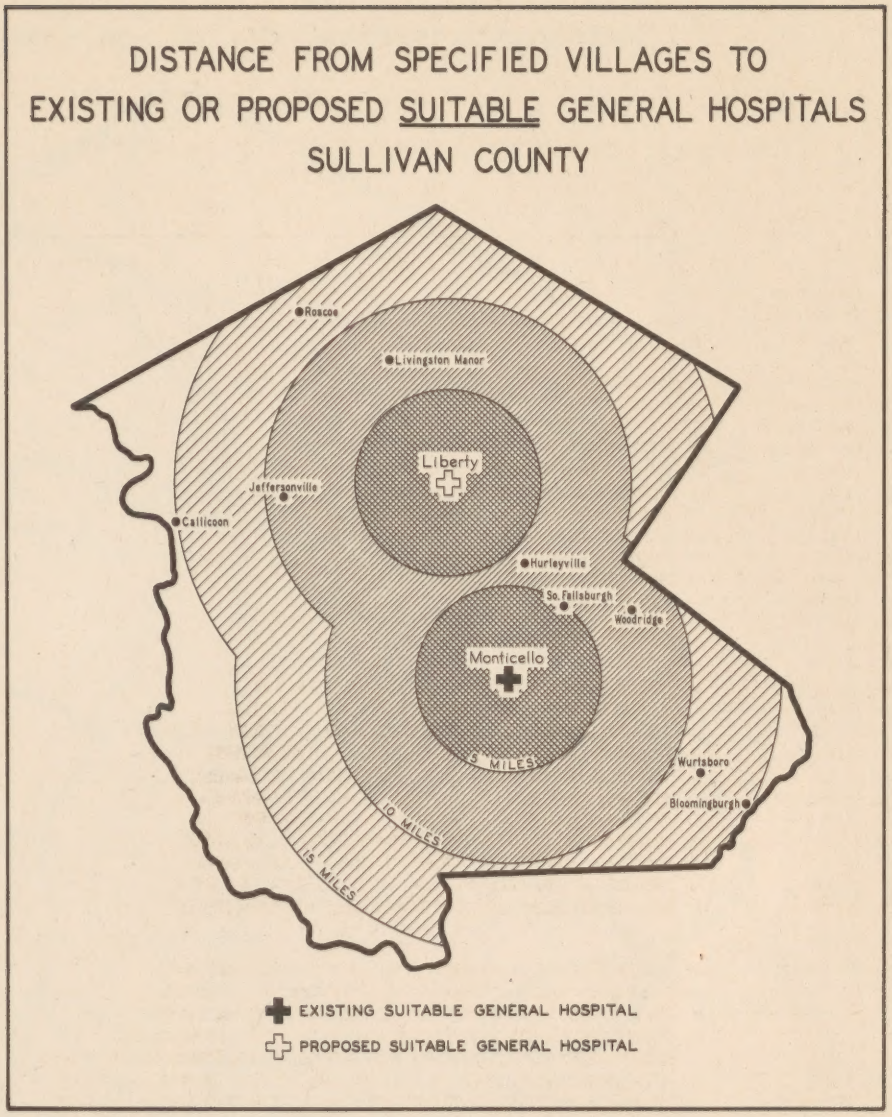
11/ Public Health Law of New York State, sec. 19-b, and Rules of the State Commissioner of Health relative to applications for state aid for public health purposes.

PRIORITY RATING OF COUNTIES FOR FEDERAL GRANTS-IN-AID FOR CONSTRUCTION OF HOSPITALS NEW YORK STATE, 1948

BASED ON PERCENT OF ESTIMATED NEED MET BY EXISTING SUITABLE GENERAL HOSPITAL BEDS*



*NEED DETERMINED ON BASIS OF BIRTH-DEATH BED RATIO AND ESTIMATED RESIDENT POPULATION AS OF JULY 1, 1945.

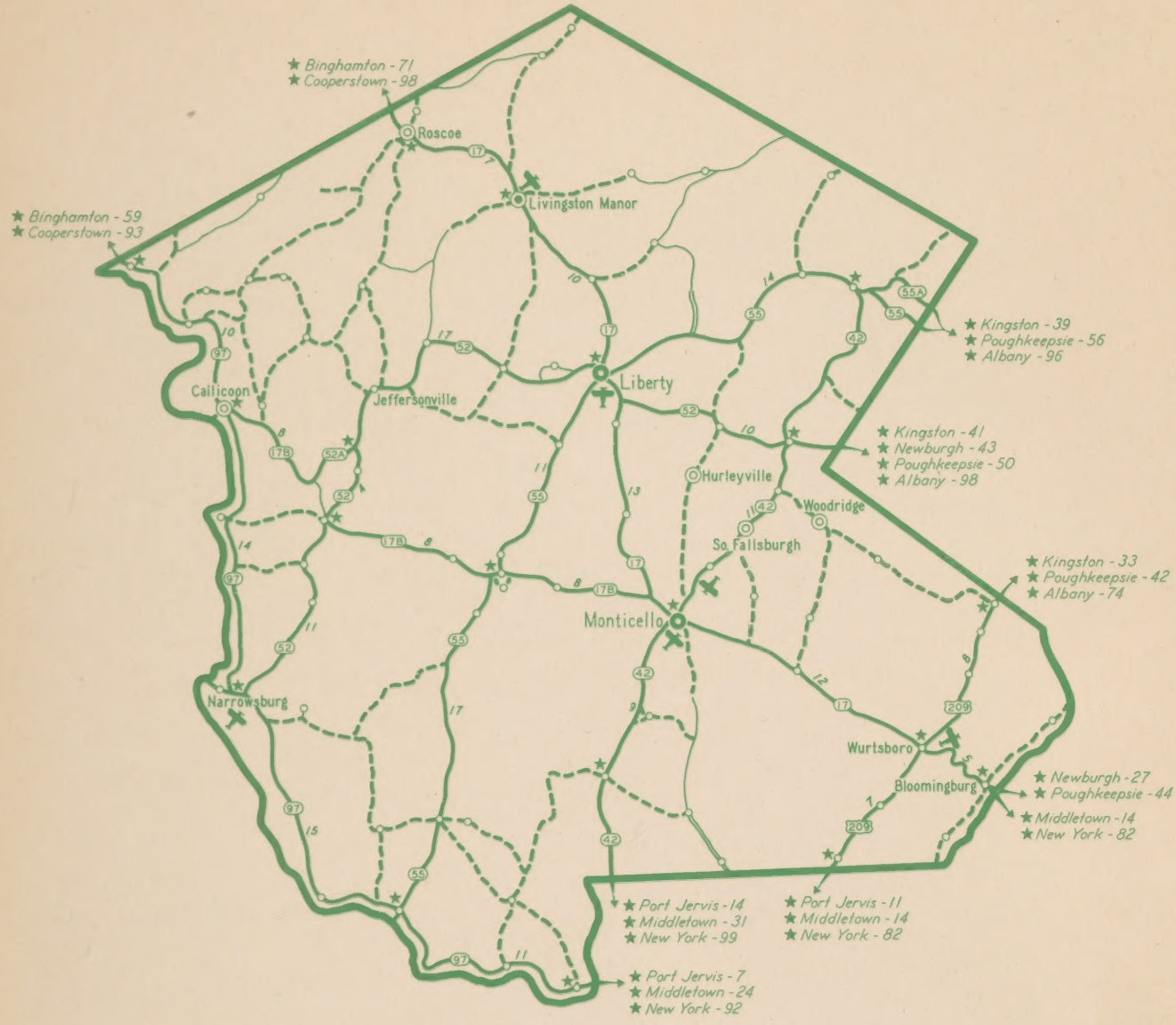


At the same time, however, it is suggested (1) that the proposed plan be given the most deliberate consideration; (2) that there be continuous cognizance of the ultimate efficiency, effectiveness and economy inherent in wise long-range planning; (3) that many factors favor the construction of a few large rather than multiple small units; and (4) that these recommendations be given the benefit of exhaustive public discussion. Therefore, it is further suggested that a non-official Sullivan County Hospital Council be formed to study and discuss the recommendations and to promote proper hospital planning in the County. Such a council should include representation from the County Board of Supervisors, the County Medical Society, the existing hospitals, the County Department of Public Welfare, business interests, granges, women's clubs, churches, other local civic organizations, voluntary public health agencies and the State Department of Health and its Regional Office at White Plains. In no other way can such a council be truly effective. In no other way can it be responsive to community attitudes and opinions.

Furthermore, if Sullivan County decides to build and operate a general hospital under County auspices, it should have a strong, voluntary citizens' organization (1) to receive contributions, bequests and similar gifts for the benefit of such a hospital; (2) to promote participation of voluntary interests in its operation; and (3) to ensure that it provides medical service of optimum quality. This function might be fulfilled either by a continuation of the Hospital Council or by another group incorporated specifically for this purpose.

PRINCIPAL ROADS AND AIRPORTS
SULLIVAN COUNTY

BASED ON DATA PUBLISHED BY NEW YORK STATE DEPARTMENT OF PUBLIC WORKS



LEGEND

- FIRST CLASS NUMBERED HIGHWAYS
- FIRST CLASS CONNECTING ROADS
- SECOND CLASS ROADS
- THIRD CLASS ROADS
- ★ 10 ★ MILEAGE BETWEEN STARS
- 209 U. S. ROUTE NUMBERS
- 42 STATE ROUTE NUMBERS
- AIRPORTS

POPULATION

- ◉ 2,500 AND UNDER 5,000
- ◉ 1,000 AND UNDER 2,500
- ◎ 500 AND UNDER 1,000
- ○ UNDER 500

SCALE OF MILES

0 5 10 15